



MEDICAL HISTORY

Name _____ Chart # _____

Birthdate _____ Allergies _____

MEDICATIONS

Date of Entry	Start Date	Date Discontinued	Medication/Dose	Initials

MEDICAL PROBLEMS INCLUDING ABNORMAL PAP SMEAR

Date of Entry	Problem	Initials

Date Reviewed/No Changes								
Initials								

Signature				
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Name _____ Chart # _____

PREGNANCIES

Date of Entry	Date of Delivery	History/Complications (C-section, VBAC, bleeding, Gestational Diabetes, Rh neg, etc)	Initials

**OTHER HOSPITALIZATIONS/SURGERIES/
BLOOD TRANSFUSIONS/EXPOSURE TO BLOOD PRODUCTS**

Date of Entry	Date of Event	Medical History/Patient Problems	Initials

FAMILY HISTORY

Family Member	Deceased (Age)	Major Medical History Date & Initial Each Entry
Mother		
Father		
Pat. GM		
Pat. GF		
Mat. GM		
Mat. GF		
Siblings		

Initials/Signature				
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